NAVAL POSTGRADUATE SCHOOL
Monterey, California

THESIS

CHAMPUS REFORM: WILL IT WORK?
AN ANALYSIS OF THE CHAMPUS REFORM INITIATIVE

by

Kevin L. Magnusson

December 1987

Thesis Advisor David R. Whipple

REPORT DOCUMENTATION PAGE

1a REPORT SECURITY CLASSIFICATION: Unclassified	1b RESTRICTIVE MARKINGS
2a SECURITY CLASSIFICATION AUTHORITY	3 DISTRIBUTION / AVAILABILITY OF REPORT: Approved for public release; distribution is unlimited
2b DECLASSIFICATION / DOWNGRADING SCHEDULE	
4 PERFORMING ORGANIZATION REPORT NUMBER(S)	5 MONITORING ORGANIZATION REPORT NUMBER(S)
6a NAME OF PERFORMING ORGANIZATION: Naval Postgraduate School; 6b OFFICE SYMBOL (If applicable): 54	7a NAME OF MONITORING ORGANIZATION: Naval Postgraduate School
6c ADDRESS (City, State, and ZIP Code): Monterey, California 93940-5000	7b ADDRESS (City, State, and ZIP Code): Monterey, California 93940-5000
8a NAME OF FUNDING / SPONSORING ORGANIZATION; 8b OFFICE SYMBOL (If applicable)	9 PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER
8c ADDRESS (City, State, and ZIP Code)	10 SOURCE OF FUNDING NUMBERS: PROGRAM ELEMENT NO. / PROJECT NO. / TASK NO / WORK UNIT ACCESSION NO

11 TITLE (Include Security Classification)
CHAMPUS Reform: Will it Work? An Analysis of the CHAMPUS Reform Initiative

12 PERSONAL AUTHOR(S)
LT Kevin L. Magnusson, MSC, USN

13a TYPE OF REPORT	13b TIME COVERED	14 DATE OF REPORT (Year, Month, Day)	15 PAGE COUNT
Master's Thesis	FROM _____ TO _____	1987 December	35

16 SUPPLEMENTARY NOTATION

17 COSATI CODES			18 SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	CHAMPUS CHAMPUS Reform Initiative

19 ABSTRACT (Continue on reverse if necessary and identify by block number)

As a result of increasing pressure to control the rising costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Department of Defense developed a comprehensive reform package known as the CHAMPUS Reform Initiative (CRI). The CRI utilizes fixed-price contracts, health enrollment and preferred provider contracts to contain costs, enhance health benefits and ensure high quality medical care. This study is a critical comparative analysis of the strengths and weaknesses of the CRI which ultimately may effect its success or failure.

20 DISTRIBUTION / AVAILABILITY OF ABSTRACT	21 ABSTRACT SECURITY CLASSIFICATION	
☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT ☐ DTIC USERS	Unclassified	
22a NAME OF RESPONSIBLE INDIVIDUAL: Prof. David R. Whipple	22b TELEPHONE (Include Area Code): (408) 646-2161	22c OFFICE SYMBOL: Code 54Wp

DD FORM 1473, 84 MAR — 83 APR edition may be used until exhausted; All other editions are obsolete — SECURITY CLASSIFICATION OF THIS PAGE

☆ U.S. Government Printing Office. 1986—606-24.

Approved for public release; distribution is unlimited.

CHAMPUS Reform: Will it Work?
An Analysis of the CHAMPUS Reform Initiative

by

Kevin L. Magnusson
Lieutenant, Medical Service Corps, United States Navy
B.S., Southern Illinois University at Carbondale, 1980

Submitted in partial fulfillment of the
requirements for the degree of

MASTER OF SCIENCE IN MANAGEMENT

from the

NAVAL POSTGRADUATE SCHOOL
December 1987

ABSTRACT

As a result of increasing pressure to control the rising costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Department of Defense developed a comprehensive reform package known as the CHAMPUS Reform Initiative (CRI). The CRI utilizes fixed-price contracts, health enrollment and preferred provider contracts to contain costs, enhance health benefits and ensure high quality medical care. This study is a critical comparative analysis of the strengths and weaknesses of the CRI which ultimately may effect its success or failure.

TABLE OF CONTENTS

I. INTRODUCTION

A. THE PROBLEM

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a program designed as an alternative medical resource available to dependents of active duty members, retirees and their dependents, and dependents of deceased active duty and retired personnel. CHAMPUS was conceived as a secondary, back-up resource to relieve pressure on overcrowded military treatment facilities (MTF).

The MTF is the primary source of medical care for eligible military beneficiaries. Care is provided essentially cost free to the beneficiary so long as resources are available. If medical care is unavailable for whatever reason, care may be sought from a civilian source utilizing CHAMPUS. CHAMPUS operates like many major medical insurance plans. The beneficiary is required to pay an annual deductible plus, depending on beneficiary status, 20 to 25 percent of the remaining allowable costs. The government pays the remainder. [Ref. 1: pp. 4-44 - 4-46]

Over the last several years CHAMPUS has come under increasing criticism. It is considered to be outdated. It does not utilize current health industry cost-containment techniques. It is too costly, too complex, and the benefits are inadequate to meet the needs of today's military families.

In response to these criticisms, the Department of Defense (DOD) has sponsored an overhaul of CHAMPUS currently known as the CHAMPUS Reform Initiative or CRI. The CRI would achieve its goals of cost containment, enhanced medical benefits, and increased patient satisfaction by utilizing fixed-price contracts to civilian health care providers. Under these contracts all the medical needs of eligible beneficiaries would be met by a coordinated effort of military facilities and civilian preferred-provider networks. Congress, after some lengthy discussion and with some reservations, has authorized a limited demonstration of the Initiative along with a phased implementation.

Proponents of the CRI hold it up as a panacea for all the military medical departments' woes. They claim that if fully implemented, it would cure not only the current ailments of CHAMPUS, but also medical combat readiness problems, medical

manpower shortfalls, and all else that might currently plague the military health service system (MHSS). [Ref. 2: p. 2]

The issue here becomes what will the CRI do? Will it, can it, under its current design, achieve what its proponents claim? Or is the CRI a disaster in the making?

B. BACKGROUND

The primary mission of the MHSS is to provide medical support to U.S. combat forces during war. The MHSS has been additionally tasked with providing a quality health benefit to active duty and retired members of the Armed Forces, their dependents and survivors [Ref. 3: p. C-2] -- in all over nine million eligible beneficiaries.

To accomplish this mission, the military operates 168 hospitals, 500 frestanding medical clinics, and 400 dental clinics. Manning these facilities are 43,030 health professionals, including 13,222 physicians, 5,021 dentists, 11,636 nurses, plus veterinarians, optometrists, podiatrists, pharmacists, psycologists, nurse practitioners, physician assistants, and others. In addition, over 146,000 enlisted and civilian personnel are utilized in support roles. [Ref. 3: p. C-2]

The MTFs are divided among the three major services: Army, Navy, and Air Force. Each service medical department is organized differently and operates its facilities independently of the other services. In the Air Force, for example, commanders of MTFs come under the direct control of the base commander, while in the Army, MTF commanders are answerable to an Army-wide central Health Services Command. In the Navy, MTF commanders report to Regional Medical Commands who in turn are under the central Naval Medical Command. [Ref. 3: p. C-3]

For 1987, DOD has budgeted $10.8 billion for medical operations. Of this total, $1.7billion is earmarked for CHAMPUS. The CHAMPUS program is operated by the DOD through the Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA). There are currently five regional fiscal intermediaries (insurance carriers) contracted to process claims for CHAMPUS. [Ref. 3: p. C-2, C-3]

The cost of health care has risen dramatically over the last ten years. In 1985 health care costs rose 7.5 percent nationwide. This is compared to only a 1.7 percent rise in the consumer price index. [Ref. 4: p. 2]

The MHSS has been hit hard by these increases, particularly in the CHAMPUS side of the house. Between 1980 and 1986 total CHAMPUS costs increased on average 17.4 percent per year while medical care costs in the private sector increased only 11.2 percent per year, on average. During this same time frame federal health care spending

other than CHAMPUS increased only an average of 10.6 percent per year. [Ref. 5: p. 22] In 1983 CHAMPUS costs totaled $1.2 billion. By 1985 They totaled $1.4 billion. $1.7 billion is budgeted for 1987, but projections indicate the final total will come in around $1.8 billion. It is estimated that by 1988 costs will run in the neighborhood of $2.06 billion. [Ref. 6: p. 22]

An additional factor in this is that CHAMPUS as currently legislated is an entitlement. This means that if the total CHAMPUS cost exceeds the CHAMPUS budget Congress *must* provide all the additional dollars. There is no legislative discretion on this. If a beneficiary qualifies for care under CHAMPUS, that person receives the care, and CHAMPUS *must* pay the bill.

Utilization of CHAMPUS has also grown tremendously. In 1983 there were 4.9 million claims submitted. By 1986 this number had risen to 7.2 million claims. [Ref. 6: p. 22] CHAMPUS is no longer the minor back-up program it was originally designed to be.

Part of the utilization problem lies in the changing structure of the population served. The All-Volunteer Force and civilian/military pay comparability have joined forces to give the American servicemember more financial freedom and security than ever before. This new-found security has resulted in a dramatic rise in the married population of the military. In 1981, for example, 40.8 percent of Navy enlisted personnel were married. By 1985 this rose to 47.4 percent, a 6.6 percent increase in the population overall, but a 16.2 percent increase in the married population. During this same time frame married populations in the Marine Corps and the Army rose 29 and 22 percent, respectively. [Ref. 7: p. 1] These increases translate to more dependents, and an increased demand for obstetric, gyncological, and pediatric care.

Recent medical blunders have also contributed to the rise in utilization of CHAMPUS. Malpractice suits [Ref. 8: p. 39] and highly publicized incidents, such as the Commander Billig[1] case, have resulted in the implementation of extensive quality assurance programs which take valuable resources away from direct patient care, reducing facility capabilities. This translates into more CHAMPUS referrals.

---

[1]Commander Donal M. Billig, a Navy surgeon at Bethesda Naval Hospital was tried in 1986 on charges of involuntary manslaughter in the deaths of five patients between 1983 and 1984. He was also charged with dereliction of duty for performing twenty-four heart operations without supervision by a cardio-thoracic surgeon.

Increased attention to the medical departments' combat readiness have been the result of such incidents as the bombing of the Marine barracks in Beirut, Lebanon. Following a review of after action reports on that incident, Dr. William E. Mayer, the Assistant Secretary of Defense for Health Affairs, testified before House and Senate Armed Services Subcommittees that, if the dead-to-wounded ratio resulting from that bombing had been reversed (there were many more dead than wounded), "it would have been not just an embarrassment, but a scandal." He further stated that, if the U.S. were involved in a full scale war at that time (1985), 65 percent of our casualties would *not* receive the surgical care they would need. Furthermore, he predicted that it would take two years (until 1987, *now*) to reduce that number to 50 percent, and that it would be 1992 before the military medical departments would be fully combat ready. [Ref. 9: p. 10]

The renewed emphasis on combat readiness has also taken its toll on direct patient care, as more medical assets are devoted towards training programs and the development of fleet and field operational units. This again results in more CHAMPUS referrals.

C. REASONS FOR CONDUCTING THIS ANALYSIS

There are several benefits to be derived from this study.

- The costs of the current CHAMPUS system have been increasing at rates far outstripping similar health programs both inside and outside the federal government. An understanding of why this is happening will help us to better evaluate the proposed reform initiative and suggest adjustments needed to ensure successful attainment of its goals.
- CHAMPUS, whatever its form, is a needed and necessary program. That is, under the current MHSS organization it is needed and necessary. It provides an important health care benefit to military dependents and retirees. Enhancement of this program could have a positive effect on recruitment and retention. It would most certainly improve the image of military medicine and increase basic morale among military families.
- Although CHAMPUS represents less than one percent of the total DOD budget, it is almost 20 percent of the DOD health budget. [Ref. 3: p. C-2, C-3] In this day of funding cutbacks where each million is carefully scrutinized, a $2 billion-plus expenditure can become significant. It is vital that we obtain the most efficient system for our money.
- If the CRI is successful in achieving its goals, it could very well contribute to resolution of the military's other medical woes. If the patient load and mix can be adjusted as proposed, combat readiness of our medical forces could be enhanced and manpower shortages and overcrowding alleviated.

D. METHODOLOGY

The methodology to be used in this study is a critical comparative analysis of current and historical literature on the military and civilian health care industries, CHAMPUS, and the CHAMPUS Reform Initiative. The CRI will be evaluated in light of industry recognized practices and experiences with similar experiments.

Chapter II of this thesis will briefly outline the primary criticisms of the current CHAMPUS system. It will also set forth the key features of the Reform Initiative and how these features are supposed to solve CHAMPUS's problems.

In Chapter III summaries of selected writings and studies relating to the CRI and similar experiments will be presented. This will provide the backdrop against which the CRI will be evaluated.

A discussion and analysis of the strengths and weaknesses of the CRI will be presented in Chapter IV. This will lead to the final conclusions and recommendations presented in Chapter V.

II. THE CHAMPUS REFORM INITIATIVE

A. CHAMPUS TODAY

The increasing pressures on the CHAMPUS program have served to emphasize its shortcomings. These shortcomings tend to be universally recognized, and on the whole, fall into the following categories:

1. Difficult Access and Poor Coordination

Access to medical care is often difficult to achieve and coordination between civilian and military providers is poor at best. [Ref. 3: p. 10]

Gaining access to a MTF is often the first problem encountered by the patient. Available appointments are few and are quickly filled. This problem is worst for patients with acute needs requiring "same day" care. If no appointments are available the patient must choose between long hours in clinic or emergency waiting rooms or seeking care from a civilian source and hoping CHAMPUS will honor their claim.

Under current policy, if needed medical care is unavailable at a military facility the patient may request a certificate of non-availability. This authorizes the patient to seek care in the civilian community under CHAMPUS coverage. The problem here is that the patient is simply pointed in the direction of the civilian world and told he must find his own care. Military providers are not authorized to make referrals to any specific civilian provider. The patient is left to his own judgement on who will best meet his medical needs. Once cut loose the patient is on his own. [Ref. 1]

A closely related problem is that once a patient leaves the military health care system, there are no provisions to recapture any follow-on or subsequent care that might be available at the MTF. The patient is simply lost to the civilian referral system for at least that episode.

2. CHAMPUS Authorized Care Inadequate

The available types of care authorized under CHAMPUS do not meet the needs of today's military families. [Ref. 3: p. 10]

This is most evident in the area of primary outpatient care. Outpatient clinics, especially pediatric, well-baby, and OB/GYN clinics are in many areas severely overcrowded. This type of care under CHAMPUS requires payment of deductibles and

co-payments which make it an economically poor substitute and in the case of many young and growing military families economically unfeasible. [Ref. 3: p. 10]

The claims procedures associated with CHAMPUS use are complicated and reimbursements are often delayed. This adds to the beneficiaries' frustration with using CHAMPUS, and at times results in the patient not even submitting a claim, just to avoid that frustration.

3. **CHAMPUS Costs Have Become Excessive.**

As mentioned earlier, the costs associated with CHAMPUS have skyrocketed and continue to rise in spite of moderated growth trends in the national health care industry. [Ref. 3: p. 10]

B. CHAMPUS REFORMED

The key features of the CRI have been specifically designed to resolve the three problem groups listed above.

1. **Improve Access and Coordination**

Two features of the CRI are to provide better access to medical care and better coordination between civilian and military providers.

a. Health Care Finder

The CRI requires the contractor to develop a "Health Care Finder" program. The concept of this program is that of a gateway -- one entry point into the total health care system. An eligible beneficiary in need of medical care contacts the "Health Care Finder" office in his area. This central office then channels the patient into either the military or civilian networks depending on his needs and the availability and capabilities of the providers. Referrals between the two networks are also handled through the "Finder". [Ref. 3: p. C-14 - C-19]

The concept of the " Finder" is simple. By channeling all patients through one gateway it eases entry into and through the system. It eliminates confusion about where to go to get needed care. All care is coordinated through one office so continuity of care can be maintained. It provides for the most efficient use of medical resources as patients can be channeled to the provider who can best and most efficiently meet their needs.

b. Resource Sharing

Another aspect of the CRI that enhances this goal is the resource sharing feature. Resource sharing involves the use of civilian providers in military facilities. In many cases the capabilities of a MTF are restricted only by manpower resources. In

such cases the contractor would provide civilian providers (MDs, nurses, etc.). The MTF would provide the physical support (workspace, consumables, etc.). Such an arrangement would allow for the most efficient use of existing physical resources. [Ref. 3: p. C-22]

2. **Enhanced benefits.**

Three features of the CRI are designed to enhance health benefits for eligible beneficiaries.

a. CHAMPUS Prime.

This is a health enrollment plan not unlike a civilian Health Maintenance Organization (HMO). Voluntary enrollment in this program obligates the enrollee to obtain all medical care through the contractors network of providers. In return the contractor agrees to provide their care at no or nominal cost. These networks are made up of both military and civilian providers accessed through the "Health Care Finder". [Ref. 3: p. C-5 - C-11]

The advantage to enrollment is that the contractor can identify the population he serves and can better (more efficiently) plan for their care. The patient benefits because he receives all needed care at no or nominal cost -- no claims forms, no deductible, no co-payment.

b. Preferred Provider Networks.

This feature would utilize the same provider network as CHAMPUS Prime, but does not require enrollment. Beneficiaries would be encouraged to use these provider networks. As an incentive to do so, the cost, although more than for an enrollee, would be significantly reduced from the 20 to 25 percent co-payment under the old CHAMPUS plan. [Ref. 3: p. C-11 - C-12]

c. Quality Assurance.

Providers contracted as part of the CHAMPUS Prime and preferred provider networks would be screened and monitored under a strict quality assurance program. This program would involve both internal and external peer review groups along with a utilization review committee. This design would provide to the beneficiary the highest quality of medical care possible. [Ref. 3: p. C-19 - C-21]

3. **Regional Fixed-Price Contracts**

Regional contracts would be awarded through a competitive bidding process to civilian comnpanies. The winning bidder would assume responsibility for development and execution of all features of the CRI, thus contracting to provide

health care to all eligible beneficiaries within the prescribed areas. [Ref. 3: p. ES-3] Using a contract process like this would provide the following advantages.

a. Nationwide Buying Power

It would utilize the nationwide buying power of the federal government. Open, competitive bidding relies on economic forces to achieve the most benefit at the least cost. [Ref. 3: p. ES-3]

b. Contractor Assumes Financial Risk

A fixed price contract places the contractor at financial risk. This gives the contractor the incentive to find the most economically efficient method of providing the required medical care. [Ref. 3: p. ES-3]

c. Military/Civilian Partnership

It sets up a partnership between the military facilities and contractor provider networks which promotes better continuity of care and cooperation between military and civilian providers. [Ref. 3: p. ES-3]

C. SUMMARY

The features of the CRI discussed in this chapter have been developed in direct response to criticisms of the current CHAMPUS system. Each of these features will be evaluated in the light of information presented in the following chapter. By examining the parts we hope to be able do draw conclusions about the health of the Initiative as a whole.

III. PREVIOUS STUDIES AND THEIR FINDINGS

The concern for the rising costs of health care is shared worldwide. This concern is mirrored in a multitude of writings in books, periodicals and newspapers. In this chapter, summaries will be provided of some of the more recent and pertinent writings on the CRI and related issues in the civilian community.

In response to a Congressional mandate and under the direction of OASD HA the Rand Corporation did an extensive study entitled "Health Care in the Military, Feasibility and Desirability of a Health Enrollment System" (June 1984). In this study they developed the idea of the MHSS organizing itself as an enrollment plan not unlike the CHAMPUS Prime preferred provider aspects of the CRI. In their plan, the role of the contractor would be played by the MTFs instead of a civilian group. In practice it would function very much like the CRI, and it would have the same objectives. [Ref. 10]

The following are some of the more pertinent conclusions of the Rand study. [Ref. 10: pp. 2, 33-35]

The costs of such a program are almost impossible to predict. Among the unknown costs that could be incurred by DOD if such a program were implemented are:

- Beneficiary co-payments arising from the current CHAMPUS program. Sufficient data are not available to even approach an accurate estimate of these costs.
- Benefit payments currently paid by other insurance companies on insurance held by eligible beneficiaries. This is estimated to be somewhere between $.5 billion and $1.5 billion per year.
- Other payments from frustrated CHAMPUS MTF eligible beneficiaries. There are no data available from which any reasonable estimate could be made.

Full implementation of a program like that outlined in the CRI will require major changes in the organization and management of the MHSS. A demonstration project might have to take place without these changes. This in itself could lead to the failure of the program demonstration.

After completion of the Rand study the OASD,HA developed their initial proposal for CHAMPUS reform. The CRI was met with immediate skepticism. In an August 14, 1986 report from the House Appropriations Committee, the CRI was

criticized as being overly ambitious. It said there were too many important items not finalized. [Ref. 4: p. 1]

In "A Report to Congress on the CHAMPUS Reform Initiative," published in November 1986, the OASD/HA defended its position and discusses the demonstration/phase-in implementation aspects of the CRI. It expresses great confidence that its plan will provide ". . . a true test of the Reform Initiative, enhance marketplace competition, facilitate nationwide implementation if successful, and maintain program stability if unsuccessful." [Ref. 2: p. 15]

The U.S. General Accounting Office (GAO) was asked by the Chairman, Subcommittee on Military Personnel and Compensation, House Committee on Armed Services, to monitor the CRI. The GAO published a report in March 1987 which identified three issues it considered to be unresolved at that time [Ref. 11]:

- Program costs may increase not decrease.
- Beneficiary satisfaction may not increase.
- Under the CRI program complexity may increase.

In light of these issues GAO recommended:

- Expeditiously develop a means of evaluating the demonstration phase. The basis upon which success or failure will be judged has not been clearly identified.
- Assure that the demonstration phase is long enough to allow for a thorough evaluation.
- Immediately inform Congress if the mandated timetable will not allow for adequate test and evaluation of the program.

About this same time Robert Hale, the Assistant Director of the Congressional Budget Office (CBO), is quoted in the *Navy Times* (11 May 1987) as saying that, from their estimates, CHAMPUS Reform ". . . might save as much as $400 million when fully in place. There is also the possibility that people who currently are not using CHAMPUS benefits, but who are eligible for benefits, could be attracted back into the system. If that happened, in the extreme case, we estimate that you could add to cost by as much as $800 million." [Ref. 12: p. 10]

In an earlier, but related report from the Blue Ribbon Panel on Sizing DOD Medical Treatment Facilities published in March 1985, the panel evaluated the cost-effectiveness of CHAMPUS against direct care in a MTF. The primary conclusion of this report was that in seven studies conducted since 1982 every one of them found it less expensive to build, expand, and man our own facilities rather than rely on CHAMPUS for health care. [Ref. 13]

The issues of cost containment, incentives, and quality of care have been discussed extensively throughout the health care industry. David Whipple, [Ref. 14] points out the need for some means of measuring health care output, without which, management control over costs, and incentives to be efficient, will remain ineffective. He goes on to recommend drastic changes in the organization of military medicine. If the cost of health care in the MHSS is to be brought under control, all costs must be taken and controlled as a whole. Costs under CHAMPUS cannot be segregated out and handled separately. He recommends that the MHSS should be organized on a tri-service, regional basis, with budget authorizations, including CHAMPUS, being allocated down to the MTF level. Local and regional authorities should be given total control and accountability for the health care needs and costs within their geographic zones of responsibility. [Ref. 14: pp. 255-256]

The manner in which health care resources are organized and allocated, and the organization's effect on the quality of health care provided has been widely discussed. In his book, *America's Health in the Balance, Choice or Chance*?, Howard H. Hiatt, M.D., discusses these and many other aspects of health care in the United States. Three topics are of particular interest to this study.

The first topic is that of the "Gatekeeper". Dr. Hiatt points out the need for one access point to health care. A reference point through which all care is sought and coordinated. This gatekeeper maintains the health record. This is necessary to ensure continuity of care and help reduce time and money, lost to repeating what has been done before. [Ref. 15: p. 48]

Second is the idea of change within a system. Dr. Hiatt cautions care in initiating change. "Changes in one part of the system often have unexpected effects elsewhere." [Ref. 15: p. 70]

The third topic he discusses is that of redundant systems in health care. Treatment facilities in the same area are offering the same services and each facility is operating below capacity.

Dr. Hiatt's conclusion is essentially the same as Dr. Whipple's, namely, that health care systems should be organized on a regional basis. *All* health care resources in the region should be controlled from one regional headquarters. *All* health care funds for the region, federal, state, and local funds, as well as private funds are all funneled through and controlled by the regional headquarters. He considers this to be "essential to the workings of the program." [Ref. 15: p. 190-208]

Wolinsky and Marder in their book *The Organization of Medical Practice and the Practice of Medicine*, [Ref. 16] draw two major points from their research. 1) The practice of medicine is affected by the differences between prepaid and fee-for-service reimbursement. 2) Certain organizational arrangements can facilitate cost containment. Such organizations are of the more bureaucratic forms which provide greater inducements through peer review. "It is in the utilization review and control mechanisms that the future lies." [Ref. 16: p.147-154]

The problem of containing costs while maintaining high quality health care has been widely studied and written about. The CRI would appear to have many of the needed elements recognized as necessary to accomplish its goals. There are also many questions which are not answered at this point. In the next chapter a more detailed analysis of the CRI will be conducted. The key features presented earlier will be examined in the hope of drawing an overall conclusion about the viability of the CRI.

IV. DISCUSSION AND ANALYSIS

In Chapter II the three major goals of the CRI were introduced along with the key programs designed to attain those goals. In this chapter the key programs will be evaluated. Strengths and weaknesses will be presented, and a preliminary conclusion drawn on the contribution of each program towards attainment of the goals of the CRI.

A. TO IMPROVE ACCESS AND COORDINATION

Two programs were identified in Chapter II as being primary contributors to achieving the dual goals of improving patient access to care and improving coordination of care between military and civilian providers.

1. Health Care Finder (HCF)

a. The Program

The features of the HCF program are aimed at achievement of both these goals.

(1) *Access.* The HCF program seeks to improve access to care by expanding the possible access points. Under the current system, a patient seeking care can choose to go to a MTF, where long waits are the norm, or a civilian provider and hope CHAMPUS will honor the claim. Telephonic access to an appointment desk is also possible, but the hours are restricted and "same-day" appointments for an acute episode are very limited.

Under the HCF program the number of access points is increased by one. Patients seeking care may also go to any contract provider and receive the needed care, with the assurance that they are covered under CHAMPUS. Access by telephone is also expanded. The HCF program requires the contractor to maintain a 24 hour a day appointment/information service.

(2) *Coordination.* The HCF program would improve coordination and continuity of health care by implementing a central coordinating agency or "gatekeeper". This agency would be responsible for:

- Maintaining the 24 hour appointment/information service mentioned above;
- Maintaining health records and insuring patient medical records are accessible at the point of health care delivery.

- development and implementation of a routing and referral system which ensures continuity of care and optimal utilization of the MTF while preserving patient freedom of choice and preference for individual and/or type of provider.

b. The Problems

Although the designers of the HCF program had improved access and coordination in mind when the program was outlined, there are some problems which may, to varying degrees hamper the attainment of those goals.

The primary problem is a conflict between the DOD/patient desire for easy access and the contractor's need for control.

The designers of the program seem to equate accessability with the number of ways that the system can be approached. Coordination through a gatekeeper is achieved after the initial patient contact. The patient would perhaps agree that this represents improved access and coordination.

The contractor on the other hand would take a different viewpoint. His survival is dependent on his making the most efficient use of available resources. To do this he must control the utilization of those resources. He must approach access and coordination as a means of controling resource use.

The provisions of the HCF program severely restrict the control of the contractor over access, but that might not be devastating if the contractor can formulate the referral and routing procedures in a way that would allow him to regain the lost control. The resulting referral and routing system, although designed to coordinate and control, may be perceived by the patient as infringing on his freedom of choice and overall access to care.

c. Conclusion

Overall the use of the Health Care Finder as specified in the CRI will do very little to improve access to and coordination of health care. The patient's desire for ease of access and freedom of choice will be in direct conflict with the contractor's need for control of resource utilization in order to provide efficient, cost effective care. Initial access may be improved, but access to follow-on or specialty care may be percieved by patients as restricted.

2. **Resource Sharing**

a. The Program

The coordination of patient care and efficient resource utilization are the goals of the resource sharing program. In support of these goals this program would allow the use of contract civilian providers in the MTF. These providers would

function as MTF staff members utilizing MTF facilities and equipment. This arrangement could be used to alleviate military manpower shortfalls and to make use of the excess capacity available at many facilities, thus improving the efficiency of the MTF. The contractor gains through expansion of the least expensive medical resource available to him.

The patient benefits because the expanding of health resources at the MTF would allow more care to be provided at that location. Coordination and continuity of care could be simplified and enhanced if care is kept within a single system.

b. The Problems

In spite of the apparant strengths of the concept of resource sharing, there is one fact which may weaken the overall contribution of this program to goal accomplishment. The fact is that the link between the MTF and the contractor is at best a weak one and there is little hope of strengthening it under this type of an organizational structure. The reasons for this are:

- The contractor has no control over resources within the MTF. Although he is charged with ensuring their efficient use, he has no real authority. The MTF commander has ultimate responsibility for everything that happens within his facility.
- The goals of the MTF commander and the contractor are not the same. In peacetime the MTF commander's primary mission is to ensure medical combat readiness of his command, and the active duty forces in his area of responsibility. Secondarily he is to provide care for the other DOD beneficiaries as space is available. The contractor's primary goal is secondary to the MTF. In a situation where conflict existed between primary goals the MTF commander's would prevail.

c. Conclusion

Resource sharing is a solid plus for the MTF in expanding its capacity and improving its resource utilization. But, because of the lack of control within the MTF and the possibility of conflicting goals, the contractor may be reluctant to make full use of the program's possibilities. The overall result may be little real improvement in coordination or efficiency of care.

B. ENHANCED BENEFITS

Benefit enhancement under the CRI is to be achieved using two different strategies. The first is an expansion of the types of health benefits offered under CHAMPUS coverage. The second is to improve the quality of care provided under CHAMPUS.

1. **Expand Health Benefits**

In an effort to expand the benefits available to beneficiaries under CHAMPUS, the CRI offers two programs -- CHAMPUS Prime and Preferred Provider Networks.

a. CHAMPUS Prime (CP)

This program is the heart and soul of the CRI.

(1) *The Program.* The benefits of an enrollment system like CP, to both the beneficiary and the contractor are recognized throughout the health care industry.

To the contractor an enrolled population means an increased ability to tailor his organization to meet the specific health needs of the populace he serves. This knowledge allows him to prescreen the providers for quality of care and cost efficiency. He can reduce the excess capacity or wasted resources associated with planning for a need that may not materialize. The money saved, through better resource planning, allows the contractor to offer more benefits for the same or fewer dollars. In theory, CHAMPUS will fund its own benefits expansion through the CP program.

The beneficiary gains through CP because he gets more benefits and pays less for them. Under CP medical care received would be at no or nominal cost. This situation is preferrable to a deductible plus co-payment. Medical care under CP therefore becomes an economic substitute for care in a MTF.

An add-on benefit to the contractor under CP is better control of resource utilization. By choosing to enroll in CP the beneficiary agrees to utilize the CP provider network. The patient preference is locked in for the period of enrollment. This reinstates some of the control lost to the expansion of access discussed earlier.

(2) *The Problems.* There are weaknesses that will have to be overcome if CP is to be fully successful in accomplishing its goals.

Enrollment plans like CP have proven themselves in the civilian community with rather stable populations. Military populations are considered to be anything but stable. Although the trend is towards more "homesteading", a significant portion of any given military community will transfer in the course of a year. The effect this instability will have on the program as whole is unclear, but it most certainly could complicate CP eligibility verification and enrollment procedures.

Another problem could be the enrollee's and the MTF's perception of enrollment entitlement for the beneficiary. A recurrent theme throughout the CRI is that the MTF is to be utilized at maximum optimality. This technically places the

MTF within the CP network. It is hard to conceive of a MTF commander agreeing with this conclusion. The military beneficiary may not see it either. The result could very well be that the enrollee would turn to the civilian CP network for care leaving MTF resources underutilized.

(3) *Conclusion.* On the whole CP is a program that, if implemented correctly, could allow for expansion of health care options. The weaknesses cited should not prove overpowering. The eligibility and enrollment problems should not hamper resource planning to a great degree because the military population is rather homogeneous and the movement of personnel is in most cases well balanced.

The perception problem is the most serious and is the result of a recurring situation in all programs of the CRI, namely the separation of powers. The military and civilian systems are separate and saying they are to work as one, won't make it happen! They are responsible through different command chains and funding chains. Each has their own separate gods to appease. Neither has any real control in the other's camp. In its prescribed form CP should not be totally undermined by this problem., but the program will be weakened and may fall short of its full potential.

b. Preferred Provider Networks

(1) *The Program.* Preferred provider networks have been used successfully in the civilian community. In function, this program sits somewhere between enrollment plans like CP and fee-for-service plans like the current CHAMPUS program.

The advantages of using a network of preferred providers is that the providers can be prescreened for cost and quality of care. This allows for some degree of resource planning, but as the population is not known to the same degree as in enrollment palns, cost controls are not as tight and savings are not as great. This limits the benefits expansion possible under such a program.

Another advantage to using a preferred provider network as required by the CRI is that beneficiaries using the network would be drawn in under the HCF routing and referral network. Under standard CHAMPUS, beneficiaries become lost to the civilian community's referral system. Under the CRI, specialty and follow-on care are retained in the system avoiding the extra cost associated with care outside the contractor's provider network.

(2) *The Problems.* The first of the weaknesses of a preferred provider network was alluded to above. The utilization patterns of an undefined population are

less easy to plan for. This means that resources cannot be as closely fitted as is possible under an enrollment system. Savings are not as great, therefore benefits could not be expanded to the same extent.

The most significant weakness is not with the preferred provider program itself, but with its coupling to the CP program. Under the CRI, beneficiaries who choose not to enroll in CP may still utilize the CP provider network, and in fact, are encouraged to do so. The effects on the CP program are still unclear since it doesn't seem to have been tried before. One thing does seem evident though. The strength of an enrollment plan lies in its knowledge of who it serves. Its provider network is tailored to the needs of its enrollees. Therein is the basis for cost savings, which allows for enhanced benefits. By introducing an undescribed population into the resource planning process are we in fact transforming an enrollment plan (CP) into a preferred provider network. We are weakening the effectiveness of the program we are counting on most.

One last problem that may be encountered if the CP network doubles for the preferred provider is in the incentives to enroll or not to enroll. Access to care, etc. will all be the same for the enrollee and the non-enrollee. The only difference would be in the cost of that care. The enrollee would pay less out-of-pocket, but how much less? If the incentives to enroll are not high enough, there will be those who will choose not to enroll simply to preserve their full freedom-of-choice. How high should the incentives be? Its never been tried before so time and experience will have to set the level.

(3) *Conclusion.* A preferred provider network by itself is a program which has proven its ability to help contain costs and enhance benefits, but as described in the CRI it may do significant damage to the CP program. This would lessen the overall benefits that could be derived if CP were left to itself.

2. **Improve Quality of Care**

The second strategy to be used to enhance benefits is to improve the quality of care provided to beneficiaries under CHAMPUS. Under the current CHAMPUS program, DOD has no real way to effectively monitor the quality of care provided. By implementing the CP and preferred provider programs health care providers are prescreened and brought under an overall quality assurance (QA) and utilization review (UR) program.

a. The Program

Under the CRI quality of care would be monitored by three programs:

- Internal Quality Assurance;
- External Quality Assurance; and
- Utilization Review.

As these programs are similar in organization and function they will be discussed as one QA/UR program.

The obvious strengths and benefits of a QA/UR program are that:

- They establish credentialing standards for providers;
- They extablish protocols and procedures for identifying and resolving quality and utilization problems before they become a significant liability;
- They set standards for appropriateness of treatment pattern; and
- They provide a database of utilization patterns for use in future planning activities.

b. The Problems

The primary drawbacks to QA/UR programs are that the require an extensive and costly administrative support system, and they draw expensive and scarce medical practitioners away from the practice of medicine, into administrative duties.

c. Conclusion

The establishment of QA/UR programs is no longer an industry option. The programs as outlined in the CRI are patterned after DOD's own programs. They are working well within DOD and if implemented correctly, should produce the desired improvements in the quality of care and the utilization data needed for good resource planning.

C. CONTROL OF HEALTH CARE COSTS

The use of regional fixed-price contracts is set forth by the framers of the CRI as the major factor to be used in controling health care costs. In defense of this decision, three advantages of using fixed-price contracts are set forth. Each of these advantages will be examined and evaluated for applicability to this situation.

1. Nationwide Buying Power

The theory behind this advantage is that the federal government controls a large amount of money. The size of these contracts ($200 million - $600 million) is expected to draw a large number of bidders. The economic forces at work during an open competitive bidding process are expected to produce the lowest possible cost for the required level of health care.

The major problem here is the supply side of the issue. The federal government can create a demand, but supply may not be adaquate to produce a competitive market. Are there enough health care organizations within our economy with adequate resources and experience to provide sufficient competition to drive the cost to its lowest level?

Even on the subregion level (the smallest region), the size of the contract is expected to be $200 million. Each contractor would be expected to provide all the programs outlined in the CRI. Civilian health care organizations, for the most part, have experience with one or the other major elements of the CRI. Their organization is based on either an enrollment, a preferred provider, or a fee-for-service program -- not all three. Experience with a comprehensive program like the CRI is practically nill. Potential bidders would be treading on unknown ground, making the risks extremely high.

If the supply side cannot provide enough bidders with the experience and resources to handle such a large and diverse program the result could very easily be a monopoly/oligopoly market, or even a no-bidder market. In either case the federal government's buying power is no real advantage.

2. **The Contractor Assumes the Financial Risk**

Under a fixed-price contract the contractor agrees to provide all services required by the contract for one given price. This type of agreement provides incentives to the contractor to operate at the most cost efficient level as possible. The incentives are derived from the fact that no more money will be forthcoming. Failure to stay within the contract budget could result in financial disaster leading to contract failure and loss of the contract. The financial risks belong to the contractor. This type of arrangement presently used in the civilian sector and has been successful in helping to keep costs under control.

The initial draft of the CRI left all of the risk with the contractor. The response of potential bidders was that the risk was *too* high. Subsequently, risk sharing features were added in writing the final draft. These features provide safeguards to the contractor to help him avoid financial disaster. They provide for renegotiation of the contract should unforeseeable economic or utilizaton problems drive costs upward.

By providing these risk sharing safeguards DOD may have fatally weakened the incentives. The value of the fixed-price is the pressure it puts on the contractor to meet or beat his budget objectives. Budget overages are money out of the contractor's

pocket. By opening the possibility of DOD covering budget overruns, the incentives have been seriously weakened.

Although weakened, the incentives may not be destroyed if a competitive bid can be counted on. In this case additional pressure is brought to bear on cost containment, because competiton will hold everything in check. Running too far over budget could mean a lost contract in the next bid. Can we count on a competitive market? The discussion above leaves that in doubt. If a monopoly market prevails DOD will be stuck with one contractor. With no competition and weak cost control incentives the risks to the contractor become minimal. The value of a fixed-price contract as a cost containment measure is reduced significantly.

3. **Military/Civilian Partnership**

The realities of the predicted military/civilian partnership have been explored earlier. Once again, briefly, the incentives to form such a partnership are weak. Two autonomous camps with different goals and objectives, and wholely separate command and funding chains will not produce the "partnership" desired. At best a weak liason realationship, not so different from the current situation, may result.

4. **Conclusion**

All in all, the three advantages listed by DOD, to using fixed-price contracts are more hopes than true advantages. The very real possibility exists that the CRI requires a program that is too large, too diverse, and too complex to attract enough bidders to make these advantages real. There would be no program with no-bidder, and should a monopoly result, very little or no progress towards cost containment would occur.

D. SUMMARY

In this chapter the three major goals of the CRI have been revisited along with their supporting programs. Strengths and weaknesses have been presented along with analysis and conclusions concerning each program's contributions toward goal achievement.

If the Reform Initiative were to work as planned it could indeed be the answer to the MHSS's medical woes. Manpower shortages could be eliminated through resource sharing. High quality health care benefits would be easily available to all beneficiaries through the HCF and CP programs. Efficiency and effectiveness could be enhanced resulting in controlled costs. Combat readiness of our Armed Forces could be increased. Unfortunately in light of the problems cited in this chapter the possibility of these things happening is slight.

Taking all of the discussion of this chapter into account there are two major obstacles to the full successful implementation of the CRI.

The first obstacle is the organizational structure of the military health services system (MHSS). The MHSS is already a house divided. Army, Navy, and Air Force medical organizations are always competing for scarce DOD health care funds. The CRI replaces a passive support system (current CHAMPUS) with an active support system. The CRI requires the active involvement of the contractor in the planning of health care resources and their utilization. In many instances the wording of the CRI gives the leading role to the contractor. The ideal would be that the contractor become a unifying, coordinating force. The reality is that on many levels the contractors will be perceived as a fourth competitor for DOD dollars.

Cooperation and coordination of effort among the four active participants will be poor because:

- Funding and command/accountability chains are separate;
- Goals are diverse and in many cases conflicting; and
- Links between the four are blurred and weak.

The second primary obstacle to success of the CRI is the lack of civilian organizations with sufficient resources and experience to successfully develop, and execute a program as large and diverse as that required by the CRI.

These two primary obstacles will be the basis of the final conclusions and recommendations presented in Chapter V.

V. CONCLUSIONS AND RECOMMENDATIONS

A. CONCLUSIONS

The primary conclusion of this study is that although CHAMPUS is in dire need of reform, the CHAMPUS Reform Initiative is not the right vehicle of change. Implementation of the overall program will prove to be a great disappointment. The goals set forth will only be marginally realized if at all.

The reasons behind this poor performance are, first, as stated in Chapter IV, the organizational structure of the MHSS will not allow it to succeed. Throughout the readings and related studies one theme was repeated almost without fail: unity. For a health system to control costs while providing an expansive benefit program, it must control all the assets -- the manpower, the facility, and the funding -- through a singular command chain. This is not the structure of the MHSS. Under the current organization, resources are controlled through two parallel chains, the military and the civilian. This duality clouds the issue of accountability, the blame for failure, the praise for success. No one is fully accountable for the total program at the operational level. This lack of accountability makes structuring incentives to promote desired behaviors essentially an impossibility.

Until DOD recognizes and corrects this fatal organizational flaw any attempt at improving the programs offered within the organization will result in disappointment.

The second reason for the failure of the CRI to achieve its goals is the result of a miscalculation on the part of DOD. That miscalculation was that the demand would generate the required supply. In this case the supply side of the health care market was unable to cope with the demand. There just are not the organizations within the industry capable of providing what the CRI requires.

This conclusion has been borne out by the results of the bidding process. Very few bids have been submitted for the areas involved in the first phase/test period. Of the four test areas North Carolina/South Carolina received no response, California/Hawaii and Georgia/Florida each received one bid, and New Orleans received two bids. Since submission, the Georgia/Florida bid has been withdrawn. causing one of the New Orleans bidders to also withdraw as that bidder was to rely heavily on the Georgia/Florida bidder for administrative support. [Ref. 17] If DOD is

to continue with the program as devised it has only two areas left, with only one bidder in each. The government's nationwide buying power, and the forces of our economy have not produced competitive bidding. What has been produced is the possibility of regional monopolies. The CHAMPUS Reform Initiative is collapsing under its own weight.

B. RECOMMENDATIONS

1. PRIMUS and NAVCARE

If the CRI is dying, where do we go from here? CHAMPUS is still in desparate need of reform. The literature reviewed has suggested one strong alternative to CHAMPUS reform. That alternative is to scrap CHAMPUS altogether and use CHAMPUS money to expand the PRIMUS/NAVCARE programs.

PRIMUS and NAVCARE are programs of the Army and Navy medical departments. They are designed to provide non-emergency outpatient care to eligible beneficiaries. The care is provided at no cost to the patient. The programs are managed by the local MTF commander and funded through his command budget. Local control allows for a tailor-made program to answer the needs of the MTF it supports. [Ref. 18]

PRIMUS and NAVCARE were developed to achieve the following goals.

- Provide quality outpatient clinical services to eligible beneficiaries.
- Reduce overcrowding and waiting times in primary care clinics at the MTF.
- Relieve medical manpower shortages.
- Contain/reduce the cost of medical care to military beneficiaries and military as a whole.

Both programs are relatively new, but the services are so pleased with the results that the currently contracted eight clinics will be expanded to 29 in 1988, and by 1992 the Army and the Navy hope to have a total of 52 such clinics in operation. [Refs. 18,19]

Organized in this fashion the weaknesses and problems identified with the current and proposed (CRI) programs could be , for the most part, overcome.

The Commander of the MTF is given control of all the funds and medical resources. He also is responsible to provide all the required medical care for beneficiaries within his zone of responsibility. Command and funding chains are now one and the same. Accountability is also clearcut. Blame or praise are more readily focused. Incentives can be designed more effectively and are more directly linkable to the behaviors desired.

By delegating the management of health care to the MTF level, the civilian supply shortage is alleviated. The contracts could be reduced in size and complexity to a level which would draw enough competition to allow economic forces to keep costs under control.

These programs appear to share the goals and intent of CHAMPUS reform. The program's organizational and funding structure seem to more closely approximate current thought on cost control measures and incentive development. PRIMUS and NAVCARE deserve a good, close look as alternatives to CHAMPUS.

2. **Preferred Provider Networks**

The use of preferred provider networks in remote areas could enhance the care of beneficiaries who reside outside the service areas of a MTF. These networks could be managed by one of the services' regional commands. This would offer a cost savings over standard CHAMPUS, it would allow for quality control and would provide better utilization records.

3. **Standard CHAMPUS**

By implementing the first two alternatives, standard CHAMPUS could be totally deleted. Organized as above outlined the MHSS could provide for the needs of all beneficiaries without using standard CHAMPUS. It is outdated and too expensive.

LIST OF REFERENCES

1. Department of Defense, Office of the Assistant Secretary of Defense for Health Affairs, *Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)*, DOD 6010.8-R, Washington, D.C., 10 Mar 1986.

2. Department of Defense, Office of the Assistant Secretary of Defense for Health Affairs, *A Report to Congress on the CHAMPUS Reform Initiative*, Nov 1986.

3. Department of Defense, Office of the Assistant Secretary of Defense for Health Affairs, *CHAMPUS Reform Initiative: Request for Proposal*, Washington D.C., 27 Feb 1987.

4. U.S. Congress, House, *Report of the Committee on Appropriations*, 14 Aug 1986, Synopsis provided in *Military Medicine*, Oct 1986.

5. Kimble, Vesta, "CHAMPUS Costs Soaring Reform in the Works," *Navy Times*, 16 Feb 1987, pp. 16, 22.

6. Kimble, Vesta, "CHAMPUS: Overburdened Program Needs Reform," *Navy Times*, 4 May 1987, pp. 8, 22.

7. Young, Sharon B., "Married Population Soars: Support Systems Pinched," *Navy Times*, 17 Nov 1986, p. 1.

8. Smith, Paul, "Malpractice Claims Up 9%," *Navy Times*, 9 May 1986, pp. 9, 39.

9. Smith, Paul, "Wartime Medicine Better, Still Lags," *Navy Times*, 30 Sep 1985, p. 10.

10. Phelps, Charles E., Susan D. Hosek, Joan L. Buchanan, Adele R. Palmer, Kathleen N. Lohr, Christina Witsberger, *Health Care in the Military, Feasibility and Desirability of a Health Enrollment System*, R-3245-HA, Santa Monica, CA: The Rand Corporation, Jun 1984.

11. U. S. General Accounting Office, *CHAMPUS Reform Initiative: Unresolved Issues*, GAO/HRD-87-65BR, Gaithersburg, MD, Mar 1987.

12. Kimble, Vesta, "CHAMPUS Reform Pushed, Resisted at Forum," *Navy Times*, 11 May 1987, pp. 10-11.

13. Department of Defense, *Blue Ribbon Panel on Sizing DOD Medical Treatment Facilities*, Point Paper, March Meeting, Second Submission, 4 Mar 1985.

14. Whipple, David, "Incentives and organizational Structure in Health Maintenance Organizations," *Advances in Health Economics and Health Services Research*, Vol 2: pp. 229-267, JAI Press Inc, 1981.

15. Hiatt, Howard H., *America's Health in the Balance, Choice or Chance?*, New York: Harper & Row, Publisher, 1987.

16. Wolinsky, Frederic D. and William D. Marder, *The Organization of Medical Practice and the Practice of Medicine*, Ann Arbor, Michigan: Health Administration Press, 1985.

17. Kimble, Vesta, "CHAMPUS Test Suffers Blow," *Navy Times*, 14 Sep 1987, p. 6.

18. Kimble, Vesta, "Walk-in Clinics Feel Overcrowding Pinch," *Navy Times* 16 Feb 1987, p. 8.

19. Maze, Rick, "Senate Backs 23 Additional Free Clinics," *Navy Times*, 12 Oct 1987, p. 1.

INITIAL DISTRIBUTION LIST

		No. Copies
1.	Defense Technical Information Center Cameron Station Alexandria, VA 22304-6145	2
2.	Library, Code 0142 Naval Postgraduate School Monterey, CA 93943-5002	2
3.	Professor David R. Whipple Code 54Wp Department of Administrative Sciences Naval Postgraduate School Monterey, CA 93943-5000	2
4.	Professor Benjamin J. Roberts Code 54Ro Department of Administrative Sciences Naval Postgraduate School Monterey, CA 93943-5000	1
5.	Department Chairman, Code 54 Naval Postgraduate School Monterey, CA 93943-5000	1
6.	LT Kevin L. Magnusson, MSC, USN Naval Medical Command (MEDCOM-5123) Navy Department Washington, DC 20372	1

Thesis
M27615 Magnusson
c.1 CHAMPUS reform: will it work? An analysis of the CHAMPUS reform initiative.